EMERGENCY MEDICAL TREATMENT AND LABOR ACT AND ITS IMPACT ON PATIENT DUMPING: A LITERATURE REVIEW

by

Silvia Marie Larson

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COMMITTEE APPROVAL

Anna Filipova Advisor

12/08/2014 Date Approved

Member

12/9/2014 Date Approved

DEAN OF GRADUATE STUDIES

Susan Cramer

12-12-2014
Date Approved

FORMAT APPROVAL

Marci Hoffman

12/5/12
Date Approved

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Chapter I: Introduction

EMTALA Background and History

The Emergency Medical Treatment and Labor Act (EMTALA) was enacted by Congress in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986, 42 U.S.C. Section 1395dd due to wide-spread concerns that hospitals were turning away or transferring patients who were in need of emergency medical care but who were unable to pay for the needed services (Medlaw, 2003). Shifting or patient dumping has occurred for years in the United States, in an effort to shift the burden and cost of care for patients unable to pay to another facility. Abel (2011) referenced the first case reported by the New York Times in 1877, although the article does say it started long before then. In this particular case, a patient with pneumonia was transferred from one hospital to another. In a matter of five minutes after arriving at the receiving hospital the patient expired. The Chambers Street Hospital alleged they did not know the patient's condition was that critical (Abel, 2011).

It is considered a case of patient dumping when a patient who requires emergency medical treatment is transferred from one hospital to another without being completely stabilized due to their inability to pay for the services required to treat the patient (Lee, 2004). Lee (2004) reports that, "When patient dumping became common, states initially sought to forbid the practice by recognizing and enforcing at common law an affirmative duty on the part of the public hospitals to provide emergency treatment to patients without regard to ability to pay" (p. 145). The common law was unsuccessful and

indigent patients still continued to be transferred without stabilization. The states then enacted a statutory duty designed to ensure that patients were treated regardless of their ability to pay for services in emergent situations. There was a lack of definition of what constituted "an emergent patient" and as a result left each hospital to determine if the patient fell into the emergent category (Lee, 2014, p. 145). States did little to impose penalties against hospitals that did not comply with the statutory duty and as a result of this the Federal government intervened (Lee, 2014).

The Hill-Burton Act was enacted by the United States Congress in 1946 as an attempt to combat patient dumping. This act mandated hospitals "to treat and stabilize any emergent patient" as a requirement of receiving federal funds for construction or modernization (Lee, 2014, p. 147). Similar to the statutory duty, this act did not clearly define what constituted "an emergent patient," no punitive consequences existed for non-adherence to the act and as a result the Department of Health and Human Services did not enforce the requirement (Lee, 2014, p. 147).

According to Cohen (2007), national attention was drawn to the issue in the early 1980's due to the sharp increase in the number of patients being inappropriate transferred. Contributing to this rise could be the number of Americans without any form of health insurance which grew from twenty-five million to thirty five million people between the years of 1977 and 1987. Government spending for healthcare was significantly decreased during this time period and hospitals were left to negotiate reimbursement rates directly with the insurers. In addition, the Medicare program was overhauled and reimbursement methodologies were changed to compensate participating hospitals with a preset dollar

amount based on the patient's diagnosis, instead of the day by day rate hospitals had been accustomed to. This change left rates of reimbursement from these government funded plans "less than desirable" (Cohen, 2007, p. 651).

Joseph (2001) reported that patients were not only being dumped for uninsured state, or Medicare and Medicaid reimbursement, but also dumped for the expense of the care they needed, such as AIDS and cancer which had a significantly higher cost to treat in relationship to the reimbursement and caps for certain services. He further reported that a hospital in Dallas claimed an increase of patient dumping cases of 70 in 1982 to over 200 cases in 1983. Epstein (1997) cited another study that examined transfers to public hospitals from private institutions in the years before the passage of EMTALA; it found that they steadily increased. The study also revealed that in a sample of 467 transfers to Cook County Hospital in Chicago during the last two months of 1983, 87% of the cases transferred because they lacked health insurance; of these about 22% received intensive care within 24 hours of their arrival (Epstein, 1997, p. 93). Nearly, 10 percent of patients died after transfer, about $2^{1/2}$ rate for those not transferred (Epstein, 1997, p. 93). Transfer delayed treatment by 5 hours, thereby increasing the risk of death transferred were not in stable condition when they arrived at the transferee hospital (Epstein, 1997, p. 93).

When Congress enacted EMTALA in 1986 it was intended to stop patient "dumping," over time, it has become a federally mandated standard of practice for "participating" hospitals (those that have a Medicare provider agreement) and "any physician who is responsible for the examination, treatment, or transfer of an individual

in a participating hospital including a physician on-call for such an individual" (Thorne, 2014, p. 1). Because the act includes hospitals that have Medicare provider agreements it reaches most hospitals, although it does not cover all the emergency rooms throughout the United States (Richards, 2012).

EMTALA Statutory Requirements

EMTALA offers strict rules and regulations that hospitals must follow to ensure patients are not inappropriately turned away and transferred to other facilities, simply because they are not able to pay for the service in an emergent situation (Hylton, 1992). Hospital administrators have an important role in ensuring hospital employees and physicians both understand EMTALA and have processes in place to ensure the law is followed (Ringholz, 2005). There are four specific statutory requirements included in EMTALA.

Medical Screening Requirement. The medical screening requirement of EMTALA stipulates that in the case of a hospital that has a hospital emergency department, if any individual, whether or not eligible for benefits, comes to the emergency department and requests, or a request is made on his or her behalf, for medical examination or treatment, the hospital must provide for an appropriate medical screening examination within the capability of its emergency department. (42 USC 1395dd, §1867(a)).

Stabilizing Treatment for Emergency Medical Conditions and Active Labor. This section of EMTALA stipulates that if any individual, whether or not eligible for benefits, comes to a hospital and the hospital determines that the individual has an emergency medical condition or is in active labor, (a) the hospital must stabilize the medical condition or to provide for treatment of the labor within the staff and facilities available at the hospital, or (b) the hospital must ensure the transfer of the individual to another medical facility (42 USC 1395dd, §1867(b) 1). The hospital is deemed to meet (a) or (b) if it follows those, but the patient either refuses to consent to the examination or treatment or refuses to consent to the transfer (42 USC 1395dd, §1867(b) 2,3).

Restricting Transfers until Patient Stabilized. First, the rule is that if a patient at a hospital has an emergency medical condition which has not been stabilized or is in active labor, the hospital may not transfer the patient unless (a) the patient requested the transfer or a physician or other qualified medical personnel, if a physician is not present, has signed a certification based upon evaluation of the information at the time and upon consideration that the benefits of medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer; and (b) the transfer is deemed appropriate to that facility (42 USC 1395dd, §1867(c) 1). Second, a transfer is deemed appropriate if (a) the receiving facility has available space and qualified personnel for the treatment of the patient; has agreed to the transfer; and has agreed to provide appropriate medical treatment, (b) the transferring hospital provides the receiving facility with appropriate medical records, (c) the transfer is effected through qualified personnel and transportation equipment, (d) meets such other requirements as

the Secretary may find necessary in the interest of the health and safety of patients transferred (42 USC 1395dd, §1867(c) 2).

Enforcement. EMTALA has three enforcement requirements. The first relates to the requirement for Medicare provide agreement. It stipulates that if a hospital knowingly and willfully, or negligently, fails to meet the requirements of section 1867(d) 1, (a) the hospital will be subject to the termination of its provider agreement or (b) the Secretary may suspend such agreement for a period of time deemed appropriate and upon a reasonable notice to the hospital and to the public (42 USC 1395dd, §1867(d) 1).

The second enforcement requirement relates to civil monetary penalties. It stipulates that a participating hospital and the responsible physician in the hospital that knowingly violate a requirement of section §1867(d) 2 are each subject to a civil money penalty of not more than $25,000 for each such violation... (42 USC 1395dd, §1867(d) 2).

The third EMTALA enforcement provision relates to civil enforcement. In cases of personal harm, any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of section §1867(d) 3A may pursue a civil action against the hospital and obtain damages available for personal injury under the law of the State in which the hospital is located (42 USC 1395dd, §1867(d) 3A). In cases of financial loss to other medical facility, any governments medical facility that has suffered a financial loss as a direct result of a hospital's violation of a requirement of section §1867(d) 3B may also obtain damages in a civil lawsuit under the law of the State in which the hospital is located (42 USC 1395dd, §1867(d) 3B). Finally, it is stipulated

that no action may be brought that is more than two years after the date of the violation with respect to which the action is brought. (42 USC 1395dd, §1867(d) 3C).

EMTALA Law Controversies

The EMTALA law has been surrounded by controversies since its inception due to the statute's original language; the interpretative guidelines issued by the Health Care Finance Administration, which have the force of law; and the various court rulings which have resulted from alleged EMTALA violations (Zibulewski, 2001). Shortly after EMTALA was passed, the same physicians who authored the study on patient dumping to Cook County Hospital noted that "monitoring, enforcement, and the effectiveness of the federal law will be crippled" by its vague definitions of emergency care and stabilization (Zibulewski, 2001, p. 340). The obscurity in the act's requirement for appropriate medical screening has caused much confusion and complexity in the judicial courts (Richards, 2012). The law's vague language (e.g., "comes to the emergency department") has caused different interpretations by health care providers and courts over time (Zibulewski, 2001, p. 341). Moreover, subsequent regulations by the Health Care Finance Administration and court rulings have extended EMTALA law language meanings over time causing additional difficulties in law implementation and different interpretations. Further, the law created significant challenges for emergency department providers to follow their policies while adhering to law's requirements (Ringholz, 2005; Zibulewski, 2001).

Purpose of the Study

The purpose of this study is to conduct a systematic review of literature about the EMTALA law requirements, interpretations, and violations. Specifically, it would address the following questions: (1) What are EMTALA's medical screening requirements and how have hospitals and courts interpreted these? (2) What are EMTALA's discharge and transfer requirements and how have hospitals and courts interpreted these? (3) What is EMTALA's reverse dumping requirement and how have hospitals and courts interpreted it? (4) How has EMTALA been enforced?

Importance of the Study

Rosenbaum, S., Cartwright-Smith, L., Hirsh, J., & Mehler, (2012) reports the current reporting system for EMTALA has been deemed weak by the Health and Human Services inspector general, and there is no currently publicly documented system for reporting violations. Additionally, Rosenbaum et al, (2012) reports that there is no empirical research that quantifies the extent of EMTALA's violations. There are significant gaps in literature containing baseline data and violation statistics since the law's inception. There has been much confusion in the industry about what is and is not included in the law (Brown, 1993), which has added to the complexity of understanding what is a true violation or not. According to Rosenbaum, in the absence of an ongoing transparent tracking system for violations and fines decreases in inappropriate transfers may not result (Rosenbaum et al, 2012). This study contributes to the literature by (1) summarizing findings from relatively recent legal analysis studies on EMTALA law

provisions interpretations, (2) identifying any gaps in the literature that require future research, and (3) identifying lessons learned that could be considered by health care providers and policy makers.

Chapter II: Methodology

Criteria for Inclusion

A comprehensive search was performed to identify articles for inclusion that met the following criteria: 1) focus on EMTALA medical screening, discharge and transfer, reverse dumping, and enforcement issues; 2) involve legal analysis of judicial, government, and provider decisions and interpretations; 3) are written in English; 4) are written between 2001 and 2014; and 5) are peer-reviewed journal articles.

Search Methods

A search of databases was conducted including; Lexis Databases: LexisNexis, OneFile (GALE), Health Reference Center Academic (Gale), MEDLINE (NLM), SciVerse ScienceDirect (Elsevier) Key words searched were EMTALA and medical screening, EMTALA and transfer, EMTALA and reverse dumping, and EMTALA and enforcement.

Retrieval of the Studies for Analysis

The use of the key words "EMTALA" and "medical screening" resulted in 95 results. "EMTALA" and "stabilization and transfer" produced 92 results, while "EMTALA" and "reverse dumping" produced 10 results. Finally, "EMTALA" and "enforcement resulted" showed 57 results. After excluding empirical research on

EMTALA provisions and enforcement issues, newspaper articles, conference proceedings, reviews, texts, and specific court cases and duplicate articles, a total of thirty articles were deemed relevant for this literature review (see Figure 1).

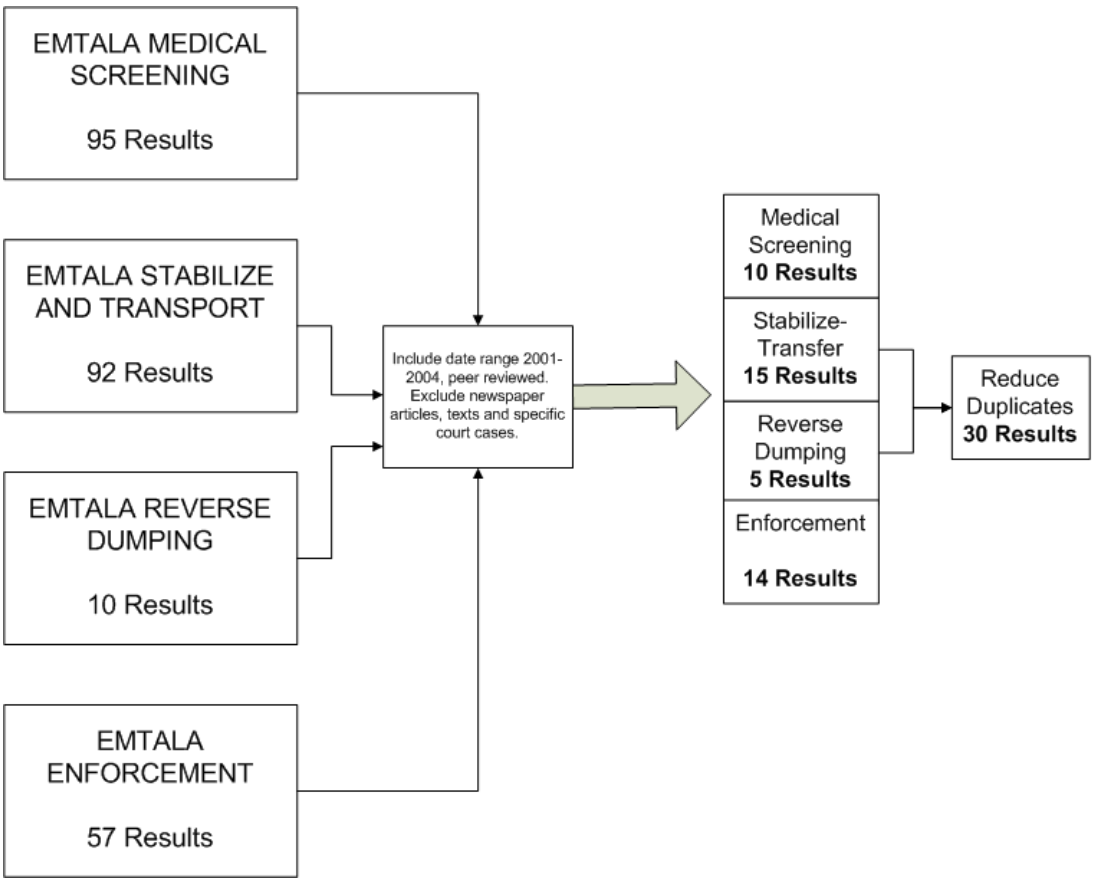

Figure 1. An illustration of the selection of publications

Analysis of the Studies Retrieved

Inductive content analysis was used to analyze the data. The purpose of using inductive content analysis is to allow research themes and trends to surface without the

limitations often found in traditional methodologies. The inductive analysis allows qualitative data to be analyzed using specific objectives and allows the researcher to analyze the data by sorting it into key themes and categories felt to be important to the researcher (Thomas, 2003). The inductive content analysis method is a rigorous method for categorizing, and analyzing documents found during the course of one's research (White and Marsh, 2006). This methodology allowed a comprehensive review of literature and developed a platform for organizing the structure of the paper.
Firstly, the full texts of the final eligible studies were read to identify the data in line with the four objectives of the review. Secondly, the identified data were listed in a working sheet. Third, categories were formed by grouping together similar topics and content areas. As a result, four categories of EMTALA impacts were identified: (1) EMTALA medical screening requirements, (2) EMTALA discharge and transfer requirements, (3) EMTALA reverse dumping requirements, and (4) EMTALA enforcement.

Characteristics of Studies Reviewed

Each accepted article was reviewed and categorized by author and year of publication, topic or purpose, and findings (see Table 1). Of the 43 legal analysis articles, ten articles focused on medical screening, fifteen focused on stabilization and transfer, five focused on reverse dumping and fourteen focused on enforcement and ten articles focused on multiple provisions. After reducing duplicates there were thirty accepted articles.

Table 1. *A Summary of Studies Researching EMTALA Requirements and Interpretations*

Author/Year	**Topic/Purpose**	**Findings**
Agraharker, 2010	Stabilize and Transfer	Requirements for call coverage provisions. Can be terminated from Medicare and Medicaid
Ai, 2001	Enforcement	Has not been effective since 1986.
Angelini & Mahlmesiter, 2005	Medical Screening	No standard licensure requirements.
Bitterman, 2002	Enforcement.	Access to HealthCare
Bluestone, 2007	Enforcement	Hospitals versus physicians
Brown, 1994	Stabilize and Transfer; Reverse Dumping	1994 provision mandating reporting of inappropriate transfers.
Brown, 2004	Stabilize and Transfer	Back up requirements for call provisions to ensure stabilization can occur.
Cicero, 2010	Medical Screening; Stabilize and Transfer; Enforcement	No national standard for screening to prevent misdiagnosis and potential inappropriate transfers.
Cohen, 2007	Stabilization and Transfer	EMTALA and medical malpractice
Conder, 2009	Enforcement	Prevention and education within the hospitals.
Gionis, Camargo, & Zito, 2002	Medical Screening; Enforcement	Broad, vague and lacks clarity. Anyone that comes to the ER regardless of insurance status. Increases in violations.

Table 2. *A Summary of Studies Researching EMTALA Requirements and Interpretations (Continued)*

Author/Year	**Topic/Purpose**	**Findings**
Gundavaram, 2003	Medical Screening	Purpose- Emergent Condition
Fedor and Perez, 2001	Medical Screening	Insurance questions should not be asked until post screening.
Frank, 2002	Stabilize and Transfer	Patient should be out of emergency
Harrington, 2007	Stabilize and Transfer	Federally governed not to discriminate.
Healthcare Financial Management, 2001	Enforcement	Penalty amounts and caps
Heinrich, 2001	Enforcement	Documentation gaps, OIG process and opportunities.
Iscan, 2004	Stabilize and Transfer; Reverse Dumping	Requires transferee to accept if capacity and specialized equipment exist.
Keough, 2001	Stabilize and Transfer	Definition of arriving at the hospital.
Lee, 2004	Enforcement	Himmelstein study, 97% of patients did not have health insurance.
Mitchiner & Charlotte, 2002	Stabilize and Transfer; Reverse dumping	Obligated to accept transfer if ability exceeds that of another hospital.
Richards, 2012	Medical Screening	Process not required to be standard, but requires consistent medical screening.

Table 3. *A Summary of Studies Researching EMTALA Requirements and Interpretations (Continued)*

Author/Year	**Topic/Purpose**	**Findings**
Rosenbaum, 2012	Stabilize and transfer; Enforcement	Lack of clarity around the stability definition. 400 violations reported between 1994-1999
Stalker, 2001	Medical Screening; Enforcement	Medical condition is defined as sufficient severity, and absence could result in serious jeopardy.
Schaffner, 2005	Stabilize and Transfer; reverse dumping	May not transfer the patient. Amendments 2003
Taylor, 2001	Enforcement	527 violations in 46 states.
Wanerman, 2002	Enforcement	Multiple ways of identifying
Williams, 1998	Medical Screening; Stabilize and Transfer	Example of emergent condition. Patient must be out of danger, prior to transfer.
Woodward, 2003	Medical Screening; Stabilize and Transfer	EMTALA does not apply if not emergent
Zibulewsky, 2001	Medical Screening; Stabilize and Transfer; Reverse Dumping and Enforcement	No questions can be asked by the transferee hospital about insurance status. HCFA investigations.

Chapter III: Results

EMTALA Medical Screening Requirements and Interpretations

A medical screening, reported by Cicero (2010, p. 419), "…requires a hospital to screen a patient who comes to the Emergency Room to determine if he or she has an emergency medical condition." The screening is meant to determine if the patient meets the criteria for a medical emergency. Stalker (2001) reports that, "Under EMTALA an emergency medical condition is defined as, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. If the hospital examines the patient and discovers that no emergency medical condition exists, then the hospital has satisfied its duties under EMTALA. However, if the hospital determines that an emergency medical condition does exist, then the hospital has a duty either to stabilize the condition or to transfer the patient to another facility for further care" (Stalker, 2001, p. 827). Schaffner (2005) reports that if the patient is found to be in a medical emergency the patient may not be treated unless requested by the patient. As an example, a patient arriving at the emergency room laboring with a child that has an umbilical cord around their neck, upon appropriate medical screening, would be found to be in medical emergency since delaying the delivery of the child may cause brain damage (Williams, 1998).

Gionis, Camargo & Zito (2002, p. 184) report that the medical screening definition is broad, vague and lacks clarity and it was not originally fully understood if EMTALA applied only to the indigent and this caused much judicial confusion initially. EMTALA has since been interpreted to mean, "…anyone who comes to the emergency room regardless of their financial status." There is not a standard process requirement for this provision of EMTALA leaving each hospital to utilize its own process and leaving judiciaries to determine on a case by case basis if the outcome of a hospital's medical screening process was a violation of EMTALA.

While EMTALA requires that a screening process be performed for patients presenting to the emergency room, it does not define set criteria for inclusion on the screening. The EMTALA law leaves the screening procedure up to each individual hospital. According to Richards (2012), while EMTALA does not require adherence to a standard medical screening process it does require the process within a hospital be applied consistently to similar patients. Additionally, Cicero (2010) reported on two separate cases where the patients had presented to the emergency room and they were both provided with medical screenings. In both cases, the patients were misdiagnosed upon screening and later one died of a heart attack and another patient lost her unborn child. The cases went to court in order to determine if the screening errors violated EMTALA and the court determined it did not. The rationale for the judiciary decision provided by the court was "EMTALA does not impose a national standard of care in screening patients, nor is it a federal malpractice statute" (Cicero, 2010, p. 421).

In a review of many other court cases, it appears that similar cases have been filed, but as long as the screening was something the hospitals used for everyone, it was not a violation of EMTALA. The argument is that these screenings may not have been in-depth enough to determine the true diagnosis, which would have led to a different level of care initially. In absence of clear and standard guidelines, it is hard to determine if these cases are truly EMTALA related or negligent care. Gundavaram (2003, p. 169) reported that the First Circuit Court determined that, although EMTALA did not define the term, appropriate medical screening examination, it did indicate the purpose of the screening is to identify an "emergency medical condition."

The act itself also does not specify the level of licensure required to perform such medical screening and leaves this to the discretion of each hospital as it relates to their by-laws. According to Angelina and Mahlmeister (2005, p. 472), a medical screening can be completed by anyone determined to be qualified for the screening, as long as it is documented within the hospital by-laws, although the Centers for Medicare and Medicaid Services "reserve the right to override the hospitals choice of qualification criteria."

Once the medical screening has been performed if the patient is deemed in medical emergency the patient must be stabilized, before a transfer of care can be initiated. However, if no medical condition is discovered, EMTALA has no jurisdiction" (Woodward, 2003, p. 2). For example, it was ruled that failing to diagnose a life threatening medical condition which resulted in the patient's death does not constitute a violation of the EMTALA provision although it could fall into a malpractice suite (Gunavaram, 2003). In another judicial case, *Correa v. Hospital San Francisco,* it was

stated that “as long as the medical screening is reasonably calculated to identify a medical emergency even if it results in misdiagnosis and leads to death, it falls within the provision standard” (Gundavaram, 2003, p.169).

The EMTALA law also conflicts with some of the managed care plans prior authorization requirements**.** While EMTALA requires a hospital to provide patients with appropriate screening and to provide sufficient care to a patient in order to stabilize them, managed care plans are not required to pay for these services. Fedor and Perez (2001) state that under EMTALA a patient should not be asked for insurance or the ability to pay for the services until such time that a medical screening has occurred and that any care necessary to stabilize the patient has been completed. This does not conflict with Medicaid and Medicare, who are not allowed to require preauthorization consents for emergency medical treatment. However, many HMOs or Managed Care contracts require that a patient sign an authorization for treatment, even in emergent situations. If the hospital does not obtain an authorization from the patient, in these cases, they are at risk for non-payment by the Managed Care organization. However, if they do ask and obtain the appropriate consent, they are in violation of EMTALA and could be charged with strict penalties.

In attempts to resolve this conflict, CMS modified its earlier position. A patient can be asked if they have insurance, and what insurance the patient carries, once stabilization has started and as long as the hospital provides care to the patient. In these cases, it makes it very difficult for a hospital to ensure they are following the rules when they are in such direct conflict of each other and modification allows for the increased

possibility that a hospital may be biased by the insurance or inability to pay for the service (Fedor & Perez, 2001).

EMTALA Stabilize and Transfer Requirements Interpretations

Once a patient is screened and believed to be in a state of medical emergency a hospital emergency room is required to ensure that a patient is out of immediate danger and has the ability to be safely and appropriated transferred to another facility, if transfer is necessary (Williams, 1998). It does not matter what insurance a patient has or their capability of reimbursing the hospital or department for services provided. Harrington reports that, "Federal statutes also govern refusals to treat based on race religion, age, gender or disability" (Harrington, 2007, p. 1). This stabilization must occur before they are moved. As an example, a patient that presents to the ED after a traumatic car accident with a large amount of bleeding and pain is thought to be in a medical emergency. Even if the Emergency Department at that particular hospital did not have services to appropriately perform major reconstructive surgery of the bone and injuries sustained, the hospital would be responsible, under EMTALA, to stabilize the bleeding and apply pain control measures for the patient to ensure they were out of the life threatening situation. Once stabilized and if it is in the best interests of the patient, consent may be obtained and the patient can be transferred to a hospital specializing in the required care. It does not matter if the patient can or is unable to pay for those services (Williams, 1998). Frank (2002) notes that regardless of reason a patient that can be cared for adequately to ensure they are out of danger should be cared for and not transferred to another hospital.

The transferring hospital must ensure the receiving hospital has the available capacity for the care of the patient, qualified staff available to provide the level of services the patient requires and must agree to accept the patient and provide the necessary medical care (Woodward, 2003, p. 256). Cicero (2010) reported that the judiciary system was called upon to determine if a hospital violates the provision of EMTALA, if the patient was misdiagnosed, or the hospital failed to identify the cause of the patient's emergent condition, or determined incorrectly that the patient was not in a medical emergency and had been stabilized as in the case of *Jackson vs. East Bay Hospital*. The court ruling was, "EMTALA does not impose a national standard of care in screening patients, nor is it a federal malpractice statute" (Cicero, 2010, p. 421). The hospitals are required to screen to the best of their hospital capabilities, "so the courts could not be intended to incorporate the objective malpractice standard of care" (Cohen, 2007, p. 1). Once the patient is deemed not in a medical emergency, the patient may be transferred. The physician providing care for the patient has full responsibility for ensuring that the receiving hospital has the appropriate level of care, and resources prior to transferring. Otherwise, the transfer could result in an EMTALA violation. The transferring provisions are not limited to the emergency departments within a hospital, "but are applicable for all patients including inpatients who may be in need of transfer to a different hospital related to severity of illness or complexity of a disease state" (Woodward, 2003, p. 257). Similarly, the stabilization requirements of EMTALA leave components of post-care to an individual hospital's interpretation.

Rosenbaum et al, (2012) references a specific Denver Health patient with a case of acute cholecystitis who was “stabilized” the day before presenting to their hospital, in need of a Gallbladder surgery. The transferring hospital did provide the patient with appropriate screening and a seven-hour course of treatment, but the case is a good example of unclear guidelines as to what stabilization really means. In that particular case the patient clearly required surgery, which that hospital could have performed. Instead, the patient was provided with the emergency room course of treatment and told to follow-up with Denver Health (Rosenbaum et al, 2012).

Woodward (2003) reports that if a hospital provides a specific level of service they must accept a patient that is transferred from another hospital unable to care for the patient, according to EMTALA**.** Hospitals are required to provide on-call coverage plans and schedules to ensure providers are available to patients who require stabilization and that appropriate care can be provided in a timely fashion. This can be a great challenge for hospital administrators, since physicians are not required to be on-call 24 hours a day, yet a hospital is required to have a 24 hour a day call plan and back-up plan, to ensure stabilization of emergencies can occur. EMTALA does not provide specific requirements of physicians, but places the responsibility for providing on-call coverage plans and back-up plans on the hospital. If an on-call physician disagrees with an emergency room physician about the ability for a medically emergent patient to be transferred “they must physically come to the emergency room, personally exam the patient and accept responsibility for the patient” (Woodward, 2003, p. 258). Physicians currently have the ability to provide call at more than one hospital at a time, and additionally are allowed to

perform routine or elective surgeries at the same time they are on call. This, coupled with limited specialty resources, can impose great scheduling complications on hospitals. Hospitals must ensure that if a physician is in the middle of stabilizing a patient at another hospital or in the middle of an elective surgery when another emergency arises, that there is a process and resources available to ensure appropriate response and care (Brown, 2004). Inadequate call provisions can lead to potential inappropriate transfers of patients, which would be a clear violation of EMTALA. Hospitals that do not abide by the regulations are at risk for severe violation penalties and can be terminated from Medicare and Medicaid programs which would severely impede patient base and reimbursement (Agraharkar, 2010).

EMTALA is very complex and has many interpretations and court decisions which have tried to clarify different components of the law. As an example, many hospitals believed the EMTALA law to be meant for patients who presented to an Emergency Room department at the hospital. However, according to Keough in a judiciary ruling referenced in HealthCare Financial Management that is not the case. The 2001 court case, *Arrington v. Wong* of a federal appellate panel in the ninth district ruled; a patient already in an ambulance, while in route to the hospital, is essentially requesting care and has "come to the hospital." The language within the EMTALA law was vague and in the *Arrington v. Wong* court case it was interpreted to mean that a patient may not be diverted while in route to the hospital, if they are in a hospital owned ambulance unless the hospital is in a state of declared diversion. This means the hospital is not currently staffed or equipped to accept any patients for any reason. It is an important

case that set precedent in that district, at the time. In *Arrington V. Wong* the patient was on his way to the hospital until communication between the ambulance and the hospital took place. The patient was in severe respiratory distress, in the ambulance heading to the hospital to seek medical care, and it was the closest hospital to the patient (Keough, 2001, p. 76).

As Keough (2001) reported when the physician found out the patient had a primary care provider at another location, the ambulance driver was directed to take the patient to the other facility. In this situation the physician did not provide a medical screening exam, prior to this direction. This case clearly indicates that patients do not necessarily need to be in the emergency room department for EMTALA to apply. It is not only an area for potential risk, but hospitals may not have interpreted EMTALA to include the transportation to their facility as having "arrived to the hospital," which reflects the complexity, multiple interpretations which could lead to unintended violations of the law (Keough, 2001, p. 76).

Adding further complexity, is the provision that a patient is not considered to have arrived at the hospital if an ambulance is maintained through protocols of the community and not hospital owned. In the year of 2003, the Center for Medicare and Medicaid Services (CMS) tried to explain and add more clarity around the definition of having arrived at the hospital or "comes to." Cicero (2010) points out that it clarifies that a patient on the way to the hospital in a non-hospital owned ambulance can be turned away when the hospital is on diversion status. This means the hospital is either having equipment issues, or shortages of staff and are unable to take care of patients

appropriately of any new patient cases. The language in the CMS clarification is thought to have made this even more complex, however, by adding that if an ambulance driver completely disregards the hospitals instruction and transports the patient to the hospital they have still "arrived at the hospital" and EMTALA requirements apply (Cicero, 2010, p. 426). If the hospital is truly unable to provide appropriate care to the patient in all good efforts and transfers the patient, they are in violation of EMTALA.

EMTALA Reverse Dumping Requirements and Interpretations

The EMTALA "reverse-dumping" provision prevents hospitals from accepting in transfer only those patients with the ability to pay for their services (Zibulewsky, 2001). Thus, when an outside emergency department contacts the hospital to request a transfer, no questions can be asked about insurance status, just as if the patient has arrived at the hospital on his or her own (Zibulewsky, 2001). The provision of the act requires a transferee hospital to accept a transfer deemed appropriate under the EMTALA guidelines as long as the receiving hospital has the specialized equipment necessary to treat the patient and the capacity to treat the patient (Iscan, 2004; Zibulewsky, 2001). The provision originally lacked clarity around the criteria for when it was permissible to refuse an appropriate transfer from a transferring hospital and when the transferee hospital becomes responsible to accept the patient. Receiving hospitals that claimed they were at capacity were later found in violation of the law because they kept an open bed in the intensive care unit for patients in the ward whose condition deteriorated, and that bed

could have been used for the transfer (Zibulewsky, 2001). If the sending hospital decided to ignore a hospital's refusal to transfer and sent the patient anyway, it was in violation of EMTALA. The receiving hospital had to treat the patient as it would any patient coming to the hospital (Zibulewsky, 2001).

Iscan (2004) reports that the Tenth Circuit court judicial ruling in St. *Anthony Hospital v. U.S. Department of Health and Human Services* added further clarity to this provision. Specialized capability and capacity were specifically reviewed in this case in terms of meaning and definition to St. Anthony who had the ability to accommodate the requested examination or treatment; St. Anthony had qualified staff available to treat the patient; St. Anthony had the necessary beds to accommodate the patient; and St. Anthony had the necessary equipment available to treat the patient. St. Anthony's argued that the transferring hospital had not established an appropriate EMTALA transfer guidelines because St. Anthony's did not accept the patient.

The judiciary ruling was that this would be an "absurd" interpretation of the ruling where the intent of receiving an acceptance from the transferee hospital was to ensure communication and notification between the two hospitals existed (Iscan, 2004). While hospitals with specialized equipment, such as burn units, heart surgery capabilities and other more specialized patient care needs are required to accept patients being transferred by other hospitals without those services, there are still cases of transfers being refused. A hospital is obligated to accept the transfer when their ability to treat the patient exceeds that of the transferring hospital (Mitchiner, & Yeh, 2002).

In 1994 a provision was added that you must notify the Health Care and Financing Administration (HCFA) if your hospital is aware of, or is the recipient of an inappropriate transfer of care, otherwise known as a patient dumping incident (Brown, 1994; Schaffner, 2005). While this is not included in the EMTALA law itself, it is included in the provider agreement that is initiated at the time an organization enters into a Medicare agreement. It is not enough that your hospital cares for the individual or even contacts the hospital to alert the administration that an inappropriate transfer occurs. The receiving hospital must report the sending hospital to the HCFA within 72 hours, but it must care for the patient within its capabilities (Zibulewsky, 2001). Consequences for non-adherence to this reporting requirement include large fines and the potential to lose Medicare reimbursement. However, Brown also notes, that fines for hospitals are so minimal that adherence is unlikely. Additionally, when hospitals were penalized and Medicare benefits were curtailed the duration of time was relatively brief and quickly reinstated diminishing any true effectiveness (Brown, 1994).

EMTALA Enforcement

The United States Department of Health and Human Services (DHHS) is responsible for enforcing EMTALA. While investigations of violations are the responsibility of HCFA, enforcement penalties and citations falls under the Office of the Inspector General of the DHHS (Stalker, 2001; Zibulewsky, 2001). Participating hospitals and physicians who negligently violate EMTALA are subject to a civil monetary penalty not more than $50,000 (or $25,000 for hospitals with less than 100

beds) for each violation (Zibulewsky, 2001, p. 344). Because a single patient encounter result in more than one violation, fines can exceed $50,000 per patient (Zibulewsky, 2001). Moreover, physicians and hospitals may face the threat of being excluded from participation in the Medicare program (Stalker, 2001; Zibulewsky, 2001). Ai (2001) found enforcement by the responsible government agencies has not been effective since 1986. According to Conder (2009), there is much that can be done to educate employees and providers around EMTALAs specific rules and regulations to increase enforcement. The DHHS, Office of the Inspector General (as cited by Zibulewsky, 2001, p. 344) reported that between 1986 and 1993, HCFA has terminated 12 hospitals from Medicare. Rosenbaum et al, (2012) found that between 1994 and 1999 approximately 400 violations were reported and investigated each year and in almost half of the reported incidents they were deemed to be true EMTALA violations. In relationship to 99 million Emergency Room visits, this number is relatively low and would suggest EMTALA's success. However, baseline data for transferring emergent patients due to the inability to pay is almost non-existent and gaps in the data include accounts that were not officially reported or investigated. According to Levine, Guisto, Meislin and Spaite (as cited by Zibulewsky, 2001), to date, about one third of all United States hospitals have been investigated by HCFA for alleged EMTALA violations, and of those, one third have been cited by the Office of Inspector General. While there are stringent reporting requirements within the act, there is qualitative data that suggests gaps in reporting for various reasons, such as retaining relationships with other hospitals and systems exist (Rosenbaum et al, 2012).

Additionally, Bitterman (2002) reports that the gaps include access to health care which is not addressed within EMTALA.

Lee (2004) reported that one of the earliest studies of patient dumping was done by Himmelstein research team and consisted of 458 patients that were transferred from a public hospital to a private hospital in a six month period. Ninety seven percent of these patients did not have healthcare insurance or were provided with government insurance in the way of Medicare or Medicaid (Lee, 2004). During a similar period Gionis, Camargo, and Zito (2002) report that while data are limited, a careful analysis of the available data shows a rise in patient dumping incidents. From 1986 to 1999, there was a 139-fold increase in violations of the performance of a medical screening examination requirement, an approximate thirty-seven-fold increase in violations of the requirement of the provision of necessary stabilizing treatment, and approximately a fifty-four-fold increase in violations of the provision regulating illegal or inappropriate transfers (Gionis, Camargo, & Zito, 2002, p. 177).

Cicero (2010) references a study that was conducted which reported an increase in patient dumping between the years of 1986 and 1998. The study indicated the issue of patient dumping had risen by 683%. Another study from Modern Healthcare states that the Federal EMTALA law was violated 975 times between the years of 1996 and 2000, noting a significant increase of confirmed violations since the EMTALA inception (Cicero, 2010, p. 421).

Wanerman (2002) reports that EMTALA violations can be identified in multiple ways. The Center for Medicare and Medicaid, “can investigate related to reports or

complaints of alleged violations from several sources, including patients, another hospital, or a report from the subject hospital itself. In addition, a surveyor may identify a potential EMTALA violation while performing a hospital licensing or recertification survey" (Wanerman, 2002, p. 470). The hospital is responsible for violations and not the physicians who care for the patients (Bluestone, 2007). The Officer of the Inspector General is then charged with determining if an EMTALA violation has occurred. Taylor (2001) reported that, "The Center for Medicare and Medicaid cited 104 for profit hospitals from 1996 to 2000 for violations of the emergency act…" (Taylor, 2001, p. 2). Taylor notes that in addition, violations occurred at 527 hospitals within 46 states in the country, which equates to 10 % of the hospitals in the United States violating the law within a short four year time period (p. 2).

Heinrich (2001) reported findings from a United States General Accounting Office Report to the Congressional Committees. There were numerous violations of EMTALA including: not screening patients, screening of patients by someone other than the physician not in keeping with the hospital's policy, non-standard application of screening to patients who were insured versus those that were not, and transferring of patients without stabilization. Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee states are part of the Atlanta Regional office which is responsible for EMTALA violations in those states. They were referenced as having the largest number of EMTALA investigations and percentage of violations investigated that were confirmed. The second highest number of investigations came from the San Francisco Regional Office who is responsible for the EMTALA violations

in the states of, Arizona, California, Hawaii, Nevada, American Samoa, and Guam. The document referenced the fact that follow through on violations was in need of improvement, even documenting violations which had occurred, but that action was still pending or had resulted in no action (Heinrich, 2001).

Heinrich (2001) concluded that the data were limited and subject to the large variations in process and methodology for reporting, investigating, assigning a violation status and applying a penalty. Incidents were only deemed to be violations when a patient care issue was involved, but the types of care issues were not broken down to specific inappropriate transfers or affected provisions. The process utilized to review the reported incidents differs between regions with one region using different screening approaches which was attributed to the difference in reported violations resulting in violations with one region at 25% and the other at 77% (Heinrich, 2001).

Chapter IV: Discussion and Conclusion

Implications from Research on EMTALA Requirements

The review of legal studies revealed that while clarity in terms of defining medical screening and stabilization has been attempted in the various judicial rulings around the EMTALA provisions, there is much that remains unclear that the courts have tried to clarify (Cicero, 2010; Cohen 2007; Gionis, Camargo & Zito, 2002;). There are no standard processes for screening to ensure each patient regardless of where they present is provided with the same level of screening, but instead each hospital is left to its own interpretation of what the screening process should contain and how it should be administered. The variances in process may result in the inability to determine that a patient is in a "medical emergency," but the law distinguishes malpractice and neglect outside the boundaries of EMTALA. The medical screening requirement is not clear and leaves much open in terms of clarity, non-conformity and effectiveness. The review of studies further showed that the rulings by the court have held that as long as a screening was done, regardless of the quality and outcome, the hospital is not in violation.

According to the studies reviewed, the definition of medical screening and stabilization of what it means to stabilize a patient defined as being in an emergent state is unclear, loosely defined and has needed judicial courts to define meaning (Cicero, 2010; Gunavaram, 2003; Rosenbaum, et al 2012). Hospitals are not given specific criteria for determining if the level of care provided in terms of stabilization is met or not and often patients are transferred to a higher level acuity hospital with questionable degrees

of stabilization. A hospital may stabilize bleeding and provide pain control, but may transport in lieu of providing a surgery for the underlying emergent situation. Although attempts have been made to clarify what it means to have arrived at a hospital, there is still uncertainty around this and risk that that ambulances can be diverted to another facility. In review of the *Beller V. Health and Hospital Corporation* case, it provided an excellent example of a patient in acute distress being transported via community wide protocols, in a non-hospital owned ambulance that was ruled not "to have arrived," at the hospital. The patient in this case was transported by ambulance to a hospital. The receiving hospital then transferred the patient to a different facility, rather than delivering the child. The child was born with brain damage as a result of the delay, however, the hospital that transferred the child upon arrival to its hospital and did not deliver the child was not found to have violated EMTALA, due to the fact that they had not arrived (Beller v. Health and Hospital Corp, 2011).

Lack of clarity also exists in the definitions around specialized equipment and capacity in the literature (Iscan, 2004;Mitchiner & Ye, 2002;). The judiciary ruling in *Anthony Hospital v. U.S. Department of Health and Human Services* attempted to provide further clarity around the definitions of specialized equipment and capacity clarifying the need for larger hospitals with specialists and equipment to accept appropriate EMTALA patients and setting precedence in future cases (Iscan, 2004). Any time a patient is refused and the hospital has had the ability through specialized equipment, specialists to accept the patient, it is deemed in a violation of EMTALA (Zibulewsky, 2001).

The review of studies also showed that violations exist around each of the provisions within the EMTALA act, although the violation data is limited and has been compromised by varying processes used to report, identify and categorize violations (Rosenbaum et al, 2012; Taylor, 2001; Zibulewsky, 2001). The literature reviewed suggests that while EMTALA was well intended, the law remains very complex and unclear, although difficult to ascertain how often, with what frequency or why due to the lack of violation data or current tracking methods. In addition to this, violation penalties have not always been impactful (Heinrich 2001; Zibulewsky, 2001). Analysis of the literature suggests wide spread violations occurring in many of the hospitals within the United State in 46 different states. It is not clear, however, if these violations are due to administrative errors in documentation, screening process and reporting or if they are constrained to inappropriate transfers or patient dumping (Taylor, 2001). There is not currently a transparent process that easily tracks the number of reported incidents, violations, reason for the violation, resolution, fines and lists hospital by name (Heinrich, 2001).

EMTALA Potential Changes and Solutions

A review of potential solutions within the literature review provided many suggestions and thoughts around improvements. Rosenbaum et al, (2012) suggests that while attempts through judiciary rulings and amendments have been made to clarify definitions of specific items within the provisions of EMTALA many areas remain vague and unclear. Screening and stabilization practice and standards need to be clearer. Other

suggestions throughout the course of the literature included: limiting EMTALA to only indigent patients that are unable to pay; allowing court action against the specific physicians, standardized screening process or algorithm to establish, "medically emergent," to ensure that all patients are treated the same regardless of which hospital facility or state they present for care in (Bluestone, 2007; Heinrich, 2001).

Cicero (2010) offered similar suggestions including: subsidizing emergency rooms and streamlining the process by implementing national standards. Another suggestion was to fully repeal EMTALA and create something completely different and holding physicians more accountable for providing care under the Hippocratic Oath they swore to, and subsidizing emergency room departments (Cicero, 2010). Bluestone (2007) argues that physicians should be held responsible for their actions and be solely responsible for the outcomes of their patients in these situations believing it will aid in decreasing the overall amount of violations, "EMTALA holds hospitals liable for violations and not specific physicians. In contrast, Bitterman (2002, p. 474), EMTALA represents "a giant unfunded government mandate." He argues that instead of micromanaging emergency care by using the stick approach, it is time society addresses the fundamental problem facing access to care: the substantial and accelerating amount of uncompensated care provided by United State hospitals and physicians. If the society values access to emergency care, then "there should be a quid pro quo: adequate funding, qualified liability immunity, or some other form of consideration" (Bitterman, 2002, p. 474).

According to Hylton (1992), violations will continue to occur until the root cause of the problem is identified. A transparent data base listing reported violations by location and hospital, reason for the violation, follow up action and penalties would allow for identification of problem areas and an opportunity to get to root cause. Hylton referenced the true reasons for patient dumping as: the high cost of health care, access to health care and the fact that everyone does not have adequate healthcare coverage to pay for services provided.

According to Conder (2009), in the short term, there are many things that we could do to attempt to reduce and mitigate the amount of EMTALA violations such as educating and ensuring hospital policies. The author suggests that there are many things compliance officers can do such as identify any policies and procedures that may put the hospital at risk for violation of EMTALA. Cohen (2007, p. 645) argues for a revised standard that will "more effectively differentiate between EMTALA and medical malpractice and will limit use of the statute to its intended purpose - prohibiting hospital emergency rooms from refusing treatment for nonmedical reasons." There is currently no transparent tracking system in place for EMTALA violations that would allow the Health and Human Service division the ability to track and categorize types of violations, and identify opportunities for improvement in clarity, conformity and adherence to the law. In the long term, there is a need to focus on collecting and analyzing the data to understand the problem and work to put legislative efforts toward that cause.

Study Limitations

This study was limited only to legal analysis studies that focused on interpreting the complexities of EMTALA law and its impact on patient dumping. The review did not include empirical studies per se that could have provided more direct evidence of EMTALA impacts. Another limitation of this review was that it covered discussion of research between 2001 and 2014, for the purposes of reviewing more recent evolution of EMTALA provisions interpretations. Finally, the study reported court cases' interpretations that were cited by other studies.

Future Research Recommendations

This review of legal studies on EMTALA identified the need for more empirical studies on EMTALA's patient dumping and HCFA enforcement success. It is important to develop an understanding of why EMTALA violations continue to occur in order to develop potential solutions in to ensure cases of patient dumping decline into the future. Future studies should also focus on an in-depth analysis of EMTALA violations across the nation to develop a hypothesis around the root cause of why these violations are occurring. Those studies would include working closely with the Officer of the Inspector General to determine a standard collection method in addition to standardizing the existing process each division currently has for determining a true EMTALA violation.

Conclusion

The intent of this paper was to review literature that focused on EMTALA requirements and interpretations and ultimately its impact on patient dumping. The review revealed that the law was very complex, much open to interpretation, unclear and not imposing and implementing strong enough consequences for non-adherence (Heinrich, 2001). The review of legal analysis studies showed an increase in patient dumping since EMTALA's enactment. However, limitations in the data found prior to EMTALA's inception exist, and many factors and inconsistencies also existed around other available data. Prior to EMTALA, reporting requirements were non-existent leaving very little in the way of determining baseline. In post- EMTALA, while reporting was required, the data might not be an accurate representation of all incidents of inappropriate transfers related to the complexity, confusion and interpretation of EMTALA, in the various processes surrounding investigation of a reported violation, and how it was processed and deemed a true violation. It is clear that inappropriate transfers of patients still exist, in post-EMTALA. However, it is difficult to determine to what extent, although some research included in this review have attempted to do this. Compliance officers at hospitals can ensure that rules and regulations around EMTALA are fully understood and court rulings which are further clarified ongoing is incorporated into these learnings.

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